STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. BUILDING 00 B. WING	09/06/2011

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KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON	5226 E 82ND ST INDIANAPOLIS, IN46250

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F0000	This visit was for a Recertification and State Licensure Survey. This visit included the investigation of Complaints IN00094064, IN00094314, IN00094904, IN00095186. Complaint IN00094064: Substantiated, No deficiencies related to the allegations were cited. Complaint IN00094314: Substantiated-Federal and State Deficiencies related to the allegation are cited at F371. Complaint IN00094904: Substantiated, No deficiencies related to the allegations were cited. Complaint IN00095186: Substantiated, No deficiencies related to the allegations were cited. Surveyor Dates: August 29, 30 ,31, and September 1, 2, 4, and 6, 2011. Facility Number: 000172 Provider Number: 155272 AIM Number: 100267130 Survey Team: Patti Allen, BSW- TC	F0000	The creation and submission of this Plan of Correction doe not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violaiton of regulation.This provider respectfully requests that the 2567L Plan of Correction be considered the Letter of Credible Allegation.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Marcy Smith, RN (August 29,30,31 and September 1,2,6, 2011) Leia Alley, RN (August 29,30,31 and September 1,2,6, 2011) Barbara Hughes, RN Karina Gates, Medical Surveyor (August 29,30,31 and September 1,2, 2011) Courtney Mujic, RN (August 29,30,31 and September 1,2,6, 2011) Census Bed Type: SNF/NF: 119 Total: 119 Census Payor Type: Medicare: 16 Medicaid: 84 Other: 19 Total: 119 Sample: 24 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on September 12, 2011 by Bev Faulkner, RN			

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F0248 SS=D	The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure 1 of 12 residents in a total sample of 24 reviewed for activity involvement received one-on-one sensory stimulating activities twice weekly as care planned. Resident # 38 Findings include: The clinical record for Resident #38 was reviewed on 9/1/11 at 10:10 a.m. The diagnoses for Resident #38 included, but were not limited to: Hypertension, Arthritis, Puritis, Mental Disorder, Senile Dementia, Pemphigoid, Neuropathy, and Constipation. The activities care plan for Resident #38 indicated the goal was the resident will receive one-on-one sensory stimulating activities twice weekly. The interventions were listed as visit in room for 1:1 sensory stimulating activities and to maintain visit log. The May/June, 2011 and July/August, 2011 In Room Visits, One To One & Independent Activity Data Collection Tool	F0248	F 248 It is the practice of this facility to ensure there is an on-going program of activities designed to meet, in accordance with the comprehensive assessment, the interests and physical, mental and psychosocial well-being of the residents are being met. 1. Corrective Action: Resident #38 care plan was reviewed and updated as appropriate. Activity Director was educated by the Executive Director on Activity/Documentation requirements.2. Identifying Others: Activity Director and Assistant will review activity care plans for those recieving 1:1 activities to ensure their care plans are being followed and documented properly. Further AD/designee will interview either the resident and/or family member using the Abaqis questions to determine resident interests/needs. 3.Systematic Changes: 1:1 activities will be documented on the One to One/Independent forms. Activity Care Plans and Attendance Logs will be reviewed quarterly during the IDT care plan meeting to ensure compliance/accountability in providing and documentation of	10/06/2011

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	Logs for Resident #38 were provided by the Director of Nursing (DON) on 9/2/11 at 11:00 a.m. The May/June, 2011 log did not indicate any activity for Resident #38 the entire month of June. The July/August, 2011 log indicated 8/17/11 as the only date of one-to-one sensory stimulating activity for Resident #38. During interview with the Activity Director on 9/2/11 at 12:20 p.m., she indicated because they have been really busy at the facility and were short staffed in August, some of the activities and logging were not completed. 3.1-33(a)		1:1 activities. 4. Executive Director/Designee will monitor 1:1 logs and observe random 1:1 (sampling of 5) activities monthly x3 and then quarterly thereafter to ensure completion of 1:1 activities. 5. Completion Date: 10-6-2011.	
F0282 SS=E	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to ensure plans of care were followed for physician ordered blood sugar monitoring and insulin coverage, central line and wound dressing changes, labs, medications, and	F0282	F 0282It is the practice of this facility to ensure that plans of care are followed for physician ordered blood sugar monitoring and insulin coverage, central line and wound dressing changes, labs, medications and x-rays.1.	10/06/2011

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	x-rays for 7 of 21 residents reviewed for plans of care being followed in a sample of 24. (Resident #49, #145, #71, #157, #152, #60 and # 153) Findings include: 1. The record of Resident #49 was reviewed on 8/29/11 at 1:45 p.m. Diagnoses for Resident #49 included, but were not limited to, multiple joint contractures, muscle weakness and post hypoxic encephalopathy, high blood pressure and heart failure. a. A recapitulated order for July, 2011, with an original order date of 6/28/11, indicated a right upper extremity splint should be applied daily at 11:00 a.m., and removed at 2:00 p.m. A recapitulated order for July, 2011, with an original order date of 6/28/11, indicated a left upper extremity splint should be applied daily at 8:00 a.m., and removed at 11:00 a.m. Review of a Treatment Record for July, 2011 indicated these splints had been applied daily as ordered. A recapitulated order for July, 2011, with an original order date of 5/12/11,		Corrective Action: It is believed that identified resident #49 is actually resident # 144 and further no compromise to the skin integrity.Resident #49 (also believed to be Resident #144) has heart rates monitored since July with the administration of the Metoprolol and has had no complications. Resident #145, #71 have had accu-checks/insulin administration recorded without complications. Resident #157 (actually Resident # 56) is allergic to tubersol and recieves annual TB screening and screens have demonstrated no signs/symtoms of TB. Annual x-ray on Recapitulation of Stay has been discontinued. CBC/BMP for resident #60 were obtained and found to be within normal limits. PICC line for resident #152 was discontinued on 9-16-2011. Resident #153 was discharged home on 9-20-11.2. Identifying Others: Medical Records pulled lists of those residents with splints, accu-checks/insulin, PICC lines, those with positive TB screens and/or x-ray and pending labs for follow up. Unit Managers/DNS/designee to review for appropriateness/follow up. 3. Systematic Changes: Inservices were held for licensed staff on 9-15, 16 and 18 and 9-22, 23 and Oct. 2, 2011 to review policy and documentation requirements for splint care, Heart Rate/ BP parameters	

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	indicated Resident #49 should have her skin integrity checked daily after the splints were removed. Review of a care plan for Resident #49, dated 5/13/11 and updated through 8/31/11, indicated a problem of "At risk for decline in joint mobility." The goal was she would tolerate wearing the splint as evidenced by no skin problems associated with splint use. Interventions included "Inspect affected limb for red or sore areas associated with the device." Review of a "Resident Weekly Skin Check Sheet" indicated Resident #49's skin was checked on July 5, 12, 19 and 26, 2011. The Treatment Record for Resident #49 for July, 2011 had a column for "Check skin integrity to ordered splint site daily after splint removal." There were no marks in this column to indicate the resident's skin had been checked. There was no documentation in the nurses' notes to indicate Resident #49's skin was checked daily after the splints were removed. During an interview with the Director of Nursing on 9/2/11 at 10:00 a.m., she indicated she had no further information		surrounding medication administration, accu-check/insulin administration/monitoring, PICC line care. Lab and x-ray logs have been initiated and inserviced to track orders. Initial assessment of residents with splints have been done. 4. Monitoring: Skin sheets will be checked weekly x3 and then quarterly x2 to ensure compliance by the wound care nurses. MAR/TAR/Skin records will be monitored daily by the Unit Manager/designee. DNS/ED will monitor weekly x3 and then quarterly x 2 to ensure compliance. Findings reviewed in PI committee monthly until compliance achieved. 5. Compliance Date: 10-6-2011	

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	to indicate the integrity of Resident #49's skin was checked after the splints were removed except weekly on July 5, 12, 19 and 26, 2011. b. A physician's order for July 8, 2011, indicated Resident #49 was to receive Metoprolol (a blood pressure medication) 75 milligrams every 8 hours and the medication was to be held if the resident's heart rate was less than 70. A cardiac care plan for Resident #49, dated 5/19/11, indicated she had a potential for "alteration in cardiac output." The goal was "Resident's heart rate will be within normal range of 60 to 90 bpm [beats per minute] while at rest." Interventions included "Monitor heart rate daily or as ordered...administer cardiac medications as ordered..." Review of a Medication Record for Resident #49 for July, 2011, indicated of the 69 scheduled times when Metoprolol was to be given (July 9, 2011 through July 31, 2011) Resident #49's heart rate was checked only 1 time, 7/11/11 at 6:00 a.m. During an interview with the Director of Nursing on 9/2/11 at 10:00 a.m., she indicated she was not able to find any other times when Resident #49's heart rate was checked prior to the administration of			

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	Metoprolol during July, 2011. 2. The record of Resident #145 was reviewed on 9/1/11 at 11:00 a.m. Diagnoses for Resident #145 included, but were not limited to, diabetes mellitus and chronic kidney disease. A care plan for Resident #145, started 12/14/10 and updated 6/6/11, indicated a problem of potential for high or low blood sugar due to diabetes mellitus. A goal was "Blood sugars will be managed through medications and diet as ordered." Interventions included, but were not limited to, "Medication and lab work as ordered," "Monitor blood sugars as ordered and report per MD orders for sliding scale insulin," "Administer Sliding Scale insulin as ordered." A recapitulated physician's order for August, 2011 with an original date of 6/14/11 indicated Resident #145 was to have Accuchecks (fingerstick blood tests to measure blood sugar) 4 times a day. A recapitulated physician's order for August, 2011 with an original date of 7/6/11 indicated Resident #145 was to receive Novolog insulin 100 units/1 milliliter subcutaneously according to the following sliding scale:			

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	Blood sugar (BS) of 151-200 = 2 units BS of 201-250 = 4 units BS of 251-300 = 6 units 301-350 = 8 units 351-400 = 10 units Review of a Medication Record for July, 2011, for Resident #145 indicated the following: On 7/13/11 at 11:00 a.m., BS was 216. There was no information to indicate he received any insulin. On 7/17/11 at 9:00 p.m., BS was 305. He received 10 units of insulin. He should have received 8 units. On 7/20/11 at 4:00 p.m., BS was 231. There was no information to indicate he received any insulin. At 9:00 p.m. BS was 235. There was no information to indicate he received any insulin. On 7/21/11 at 4:00 p.m., BS was 188. There was no information to indicate he received any insulin. At 9:00 p.m., BS was 186. There was no information to indicate he received any insulin. On 7/22/11 at 9:00 p.m., there was no information to indicate an Accucheck was done or insulin given. On 7/26/11 at 4:00 p.m., BS was 296. He received 10 units of insulin. He should have received 6 units. On 7/27/11 at 9:00 p.m., BS was 314. He received 10 units of insulin. He should have received 8 units.			

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A facility policy, dated 9/1/11, received from the Executive Director on 9/6/11 at 3:55 p.m., titled "Blood Glucose Monitoring, indicated "Procedure...1. Check physician's order for blood sugar testing...26...If the physician has established blood sugar parameters, follow physician's orders..."

Further information was requested from the Director of Nursing at 5:00 p.m. on 9/2/11. No further information was provided by final exit on 9/6/11 at 4:45 p.m.

3. Resident #71's clinical record was reviewed on 8/31/2011 at 1:20 p.m. The record contained documentation of Resident #71 having been admitted to the facility on 10/20/2010. The record contained diagnoses that included, but were not limited to, Diabetes Mellitus, Dementia, Coronary Artery Disease, and Anorexia.

The physician orders recapitulation indicated; Accucheck (blood sugar) 2 times daily, 3 times weekly, use hypoglycemic protocol if less than 60 was dated 4/22/2011. Review of the diabetic flowsheets revealed separate monthly sheets with none dated for July, 2011. Interview with the DoN on 9/1/2011 at 3:25 p. m., indicated that

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	documentation of Accucheck's completed in July cannot be found. 4. Resident #157's clinical record was reviewed on 8/30/2011 at 2:00 p.m. The record contained documentation of Resident #157 having been admitted to the facility on 1/12/2005. The record contained diagnoses that included, but were not limited to, Breast Cancer, Profound Mental Retardation, Seizure Disorder, and Dysphagia. The physician orders recapitulation indicated, must have annual chest x-ray due to positive PPD, due in November was dated 1/12/2005. Review of the resident annual screen, dated 11/12/2010, indicated that Resident #157 did not have any the signs or symptoms of TB and a checkmark was placed next to the statement that no action needed to be taken. Interview with the DoN on 9/1/2011 at 1:30 p. m., indicated that the resident only has a yearly screen done and would only be given a chest x-ray if she exhibited symptoms of TB. 5. The clinical record for Resident #60 was reviewed on 8/31/11 at 10:15 a.m. The diagnoses for Resident #60 included,			

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	but were not limited to: Hyperlipidemia, Anemia, Hypertension, Chronic Stage III Kidney Disease, and Diabetes. The September, 2011 physician's recapitulation orders indicated a CBC (Complete Blood Count) lab and a BMP (Basic Metabolic Panel) lab to be drawn monthly beginning 7/29/11. Neither the results of these labs nor any information indicating the labs were drawn in the month of August, 2011 could be found in the clinical record. During interview with the DON on 9/1/11 at 8:57 a.m., she indicated the lab orders for the CBC and the BMP were mistakenly faxed to the pharmacy instead of the lab, no one caught the mistake, and the labs were not drawn as ordered. 6. The clinical record for Resident #152 was reviewed on 9/1/11 at 2:50 p.m. The diagnoses for Resident #152 included, but were not limited to: Depression, Hyperlipidemia, Morbid Obesity, Heart Disease, Renal Dialysis Status, and Left Foot Transmetatarsal Amputation. The September, 2011 physician's recapitulation orders indicated PICC (Peripherally Inserted Central Catheter)			

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	line dressing change weekly (Box Day) beginning 8/2/11. The August, 2011 Midline and CVAD (Central Venous Access Device) Documentation Form provided by the DON on 9/2/11 at 11:00 a.m., indicated Resident #152's PICC dressing was to be changed every 7 days on the 6-2 shift. The form had boxes outlined for 8/5, 8/12, 8/19, and 8/26/11 with no initials inside the boxes to indicate the dressing change was done. No other documentation could be found in the clinical record to indicate a dressing change was done in the month of August, 2011. During interview with the DON on 9/2/11 at 11:26 a.m., she indicated she did not have any information indicating a dressing change to the PICC line was done the entire month of August, 2011. 7. The record of Resident #153 was reviewed on 8/29/11 at 10:00 A.M. Diagnoses for Resident #153 included but were not limited to end stage renal disease and open leg wounds of non healing ulcers. On 8/29/11 at 10:30 A.M., the medication records of July and August, 2011 of			

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	Resident #153 were reviewed and indicated that the medicines were not given according to physician orders. Medications not given were designated by nurses initials in a circle or space not marked. A designated space was provided on the back of record for explanations for the circling or omissions to be put on appropriate line by the date. No notations on records for non administration of the following medicines could be found: Heparin, 5000 units, dispensed by syringe every 8 hours - missed doses were found on 7/3, 2:00 P.M. (circle) - 7/4, 2:00 P.M. (circle) - 7/8, 10:00 P.M. (circle) - 7/9, 6:00 A.M. (circle) - 7/10, 2:00 P.M. (circle) and 7/11, 6:00 A.M. (circle). Sodium Thiosulfate, 25gm on dialysis days after intravenous administration on Tuesday, Thursday and Saturday - missed doses were found on 7/12 (space) - 7/14 (space) and 7/21 (space). Renagel, 800 mg, 4 tabs 3 times a day with meals - missed doses were found on 7/13 at 8:00 A.M. (circle) and 12:00 P.M., (circle) - 7/15 at 8:00 A.M. (space) and 12:00 P.M., (space) - 7/19 at 12:00 P.M., (circle) - 7/20 at 5:00 P.M. (space) - 8/5 at 8:00 A.M. (space) and 12:00 P.M. (space) - 8/11 at 8:00 A.M. (circle) -			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON	5226 E 82ND ST INDIANAPOLIS, IN46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	8/12 at 8:00 A.M. (circle) and 12:00 P.M. (circle) - and 8/19 at 12:00 P.M. (space). Fluoxetine HCL, 10 mg. capsule, 1 capsule by mouth every day - missed doses were found on 8/5, (space) - 8/11, (circle) - 8/12 (circle) - and 8/19 ((space). Cinacalet, 60 mg tab, 1 tab by mouth daily with food - missed doses were found on 8/5 - (space) - 8/10 (circle) and 8/11 (circle). Pregabalin, 50 mg capsule, 1 capsule by mouth every day at bedtime - missed doses were found on 8/19 (space) and 8/31 (circle). Prostat 64, 30 ml by mouth 3 times daily - missed doses were found on 8/9 at 8:00 A.M. (space) and 12:00 P.M. (space) - 8/11 at 12:00 P.M. (space) 8/12 at 12:00 P.M. (space) - 8/15 at 12:00 P.M. (space) - 8/19 at 8:00 A.M. (space) and 12:00 P.M. (space) and 8/26 at 12:00 P.M. (space). Oxycodone SA, 40 mg by mouth 2 times a day - missed doses were found on 7/3 at 9:00 A.M. (space) 8/5 at 9:00 A.M. (space) - 8/15 at 9:00 A.M. (space) and 12:00 P.M. (space) - and 8/16 at 9:00 A.M. (space).			

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	An interview was conducted with LPN #6 at 2:15 P.M., concerning charting of medications for Resident #153. She said that circles around initials on the medication administration record meant the medication was not given by the nurse whose initials are in the circle, and an explanation was to be placed on the back of the sheet. She indicated if there was a circle with initials, the medication was not given for some reason at that time, and if there was a blank space on the record the medication may not have been given or the person may have been gone. She said she was not sure why there were circles or blank spaces, indicating medications had not been given for physician ordered medications, for Resident #153. During an interview on 9/1/11 at 5:00 P.M., with the DON and Executive Administrator of the facility they were informed that documentation of medications not given for Resident # 153 was missing in the medication record. On 9/2/11 at 9:30 A.M., the DON indicated that no other medication documentation could be found for Resident #153. 3.1-35(g)(2)			

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F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure a resident with diabetes was managed and treated according to physician orders for 1 (Resident #84) of 3 diabetic residents reviewed from sample of 24. Resident # 84 Findings include: 1. The record of Resident #84 was reviewed on 8/31/11 at 11:00 A.M. Diagnoses include but is not limited to Diabetes Mellitus.	F0309	F 309It is the practice of this facility to ensure that each resident recieves the necessary care and services to attain or maintain the highest practicable physicial, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. 1. Corrective Action: There was no adverse outcome to resident #84 and he continues to reside in facility.2. Identifying Others: Residents recieving insulin coverage based upon sliding scale orders were reviewed and no negative findings resulted. Orders reviewed by NP/MD for appropriateness. 3.Systematic Changes: DNS	10/06/2011

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	A physician's order, dated 8/30/11, for Resident #84 indicated a sliding scale insulin coverage was be used for blood sugar results to determine the amount of Novolog SS insulin units to be given as follows: 100 - 200 = 2 units 201 - 250 = 4 units 251 - 300 = 6 units >300 = 8 units On 9/4/11 at 10:00 A.M., a review of the treatment record for Resident #84 indicated a blood sugar test was done at 6:00 A.M., resulting a reading of 192, requiring 2 units of insulin be given according to sliding scale, but was not marked as administered. The facility DON was interviewed on 9/4/11 at 10:20 A.M., reviewed the chart and acknowledged that there was no documentation for administration of insulin at the 6:00 A.M. blood sugar check. On 9/4/11 at 10:30 A.M., the DON contacted the nurse on duty at 6:00 A.M., who indicated that she had not given the insulin required by the sliding scale order. At 10:45 A.M., the DON directed 2 units of Novolog insulin to be given by LPN #5. According to the Lexi-Comp Geriatric Dosage Handbook and the Geriatric		educated nursing staff on 9-15, 16, 18 and will again on 9-22, 23, and Oct. 2, 2011 with regards to the administration of insulin per sliding scale orders and with education specific to long/short term acting insulin coverage. New orders are reviewed daily in the clinical meeting to ensure compliance with the implementation of orders and for necessary follow up.4. Monitoring: Accu-check/Sliding Scale documentation tool have been implemented and inserviced to nursing staff by the DNS on 9-15, 16 and 18 and 9-22, 23 and Oct. 2, 2011. Unit Manager's/designee will be responsible to monitor the Medication Administration Records (MAR) daily for compliance. DNS/Executive Director will monitor Accu-check insulin logs/MAR weekly x3 and then quarterly x2 for compliance and will report progress to the PI committee for follow up and/or until compliance is achieved.5. Compliance Date: Oct. 6, 2011	

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	Medication Handbook (published in partnership with the American Society of Consultant Pharmacist), Novolog insulin is a rapid acting insulin which is normally administered as pre-meal component of an insulin regimen. Typical administration time would be 15 minutes prior to meals with onset at 15 minutes after administration. 3.1-37(a)			
F0314 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on clinical record review, observation, and interview, the facility failed to ensure promotion of healing and	F0314	F 314It is the practice of this facility to ensure promotion of healing and prevention of new pressure sores for developing.1.	10/06/2011

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	prevention of new pressure sores from developing for 1 of 5 residents reviewed for pressure ulcers in a total sample of 24 residents. Resident #118. Findings include: Resident #118's clinical record was reviewed on 8/30/2011 at 10:30 a. m. The record contained documentation of Resident #118 having been admitted to the facility on 6/30/2008. The record contained diagnoses that included, but were not limited to, Paraplegia, Major Depressive Disorder, Seizure Disorder, and Neurogenic Bladder. Review of the weekly pressure ulcer report provided by the DoN on 9/2/2011 at 11:20 a. m., indicated on 6/17/2011 that an Ischial Tuberosity (lower portion of the hip bone) pressure ulcer was healed. Review of the wound progress note, dated 6/24/2011 and provided by the DoN on 8/31/2011 at 4:54 p. m., indicated, "Dermatitis excoriation to the right posterior thigh with partial thickness." Review of the wound progress note, dated 7/13/2011 and provided by the DoN on 8/31/2011 at 4:54 p. m., indicated that a Stage 2 pressure ulcer to the right Ischium reopened.		Corrective Action: Wound nurse performed a complete skin assessment and orders reviewed for appropriateness. 2. Identifying Others: Wound care orders/care plans will be reviewed by the wound care nurses for appropriateness and updated as necessary. Skin sweep of all residents will be done by wound nurses. 3. Systematic Changes: Skin assessments will be audited by wound care nurses weekly. Licensed staff recieved wound care education at mandatory wound fair held on 9-15-2011. Wound Care Nurses/ DNS re-educated licensed staff with regards to documentation requirements on 9-15, 16, 18 and 9-22, 23 and Oct. 2, 2011.4. Monitoring:Skin sheets will be monitored by UM/Designee daily. Wound rounds will be done weekly by wound team to ensure current treatments are appropriate. DNS/Designee will monitor weekly x3 and then quarterly x 2 to ensure compliance. Results will be reviewed by the PI committee monthly until compliance is achieved. 5. Compliance Date: 10-6-2011.	

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	Interview with the wound care nurse, LPN #7, on 9/2/2011 at 10:05 a. m., indicated that Resident #118 had a pressure ulcer that developed from a hospital stay and was resolved in June of 2011 but reopened after incontinence dermatitis developed on the right upper thigh/Ischium, because the resident has very slow healing skin. Review of the weekly skin check sheet provided by the DoN on 9/2/2011 at 11:20 a. m., indicated blank assessments for the following weeks, dated; 6/21/2011, 6/28/2011, 7/05/2011, 7/12/2011, 7/19/2011, and 7/26/2011. A request for any other documentation of skin interventions or wound assessments from this time period was also made at this time. Review of the alteration in skin integrity care plan, last dated 5/4/2011, indicated that interventions included weekly skin assessments. Review of the potential for skin breakdown care plan, dated 8/22/2011 and provided by the DoN on 8/31/2011 at 4:54 p. m., indicated that interventions include licensed nurse to complete weekly skin checks, and moisture barrier per facility protocol.			

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	Review of the Pressure Ulcer Prevention policy provided by the DoN on 9/2/2011 at 10:55 a. m., indicated, "assess resident from head to toe for skin and effectiveness of care plan interventions and document in the resident's medical record at least weekly." During an observation of Resident #118's wound care provided by wound care LPN #7 on 9/02/2011 at 10:35 a.m., it was observed that no barrier cream had been applied on buttocks area and the resident was wearing incontinence briefs. There was a foam dressing covering the Stage 2 Pressure Ulcer. An interview with wound care LPN #7 on 9/02/2011 at 10:35 a. m., indicated Resident #118 was provided barrier cream each shift to prevent skin breakdown but currently had none on because the day shift nurse knew that it would be applied during wound care. 3.1-40(a)(2)			

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F0322 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. During observation, interview and record review, the facility failed to check placement of a gastric tube prior to providing liquid feeding and medications for 1 of 1 resident observed in the sample of 24. Resident #98. Findings Include: The clinical record for Resident #98 was reviewed on 8/30/11 at 9:30 a.m. Diagnoses for Resident #98 included but were not limited to, tracheostomy (a hole in the trachea for breathing), COPD (Chronic Obstructive Pulmonary Disease), oropharyngeal cancer (cancer of the throat), and gastric tube (a tube placed into the stomach for liquid nutrition and medication for people who are not able to swallow or eat). During an observation of gastric tube (g-tube) feeding and medication administration on 8/31/11 at 3:00 p.m., LPN #4 was observed flushing (pouring	F0322	F 322It is the practice of this facility to ensure that placement of gastric tube is checked prior to providing liquid feeding and medications.1. Resident #98 had no residual present when procedure was initiated by LPN #4 (who is actually an RN). 2. Identifying Others: Licensed nursing staff caring for those with G-tubes will have competencies completed by 10-6-2011.3. Systematic Changes: Nursing staff has been educated on 9-15, 16 and 18 and 22, 23 and Oct. 2, 2011 with regards to checking placement of gastric tube prior to the administration of liquid feeding and/or medications. Licensed staff are also educated and required to perform a return demonstration of competency upon hire and then annually thereafter, with performance review and as needed, if appropriate.4. Monitoring: Observations of gtube proceedures by Unit Managers/designee on a random basis for 3 weeks and then quarterly x2 to assure compliance is achieved. Random audits will be made	10/06/2011

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	liquid through the tubing) the g-tube with water without first checking to make sure of the placement of the g-tube in the stomach. A physicians recapitulated order for September, 2011, included "Check tube placement before insertion of formula, medication administration, and flushing tube or at least every 8 hours." A facility care plan, dated 8/2/11, titled "Tube Feeding," indicated a problem for Resident #98 was "risk for complications associated with feeding tubes including aspiration." A goal of "Will have no signs or symptoms of aspiration through next review" and an intervention to achieve such goal included "Check placement prior to med, feeding or water administration." During an interview with the Administrator on 8/30/11 at 3:40 p.m., she indicated the staff nurse would normally check placement of the g-tube, but at the time of the observation she was nervous. A facility policy, dated 4/20/11, and titled "Medication via Feeding Tube" included "Check feeding tube placement."		by DNS/Executive Director/Designee weekly x2 and then quarterly x 2 to ensure compliance and will report to PI committee until compliance is achieved. 5. Compliance Date: 10-6-2011.	

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	3.1-44(a)(2)			
F0323 SS=E	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. A. Based on observation, interview and record review, the facility failed to maintain supply closet doors were locked in order to provide a safe environment for 66 independently mobile residents of residing on both the "Brookshire" and "Cambridge" units, out of 119 residents residing in the facility. Resident #'s 1, 5, 7,9, 12, 13, 14, 16, 21, 22, 23, 25, 26, 27, 29, 30, 31, 34, 36, 37, 39, 40, 42, 43, 50, 51, 52, 55, 56, 58, 66, 67, 68, 70, 72, 73, 74, 79, 82, 84, 86, 92, 102, 107, 110, 111, 113, 114, 116, 117, 119, 120, 129, 131, 132, 133, 135, 136, 140, 141, 142, 146, 147, 152, 153, 157. B. Based on observation, interview and record review, the facility failed to maintain a safe environment for 1 of 1 residents reviewed for elopement in a sample of 24 residents. Resident #56. Findings Include: A.1. During an observation of the facility on 8/29/11 at 2:00 p.m., two supply	F0323	F 323It is the practice of this facility to ensure that resident environment remains as free of accident hazards as possible; and that each resident recieves adequate supervision and assistance to prevent accidents. 1. (A.) Residents #1,5,7,9,12,13,14,16,21,22,23,25, 26,27,29,30,31,34,36,37,39,40,42 ,43,50,51,52,55,56,58,66,67,68,7 0,72,73,74,79,82,84,86,92,102,10 7,110,111,113,114,116,117,119,12 0,129,131,132,133,135,136,140,1 41,142,146,147,152,153, 157 were unaffected. Executive Director validated that all supplies closets had appropriate and effective locking mechanisms on 8-20-2011. (B.) Resident #56 was returned into the facility without incident and resides in facility. The "Wander and Elopement Risk Assessment" for resident #56 from August, 2010 - August, 2011 identified resident as a "wander risk" but did not identify her as an "elopement risk". Further, resident #56 had had no previous incidents of exit seeking behaviors. 2. Identifying Others: (A.) Supplies closets throughout facility were inspected and	10/06/2011

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	closets were unlocked. A supply closet on the, "Brookshire" unit was unlocked, inside the closet were the following items, Hand Sanitizer (with a warning to keep away from children and suggested to seek professional assistance or consult poison control in case of accidental ingestion) Mouth Wash (with a warning to keep away from children, which may indicate, an adult who was cognitively impaired may not understand this item may be hazardous to their health) Denture Cleaner (with a warning to keep away from children) Shave Cream Toothpaste Body Soap and Lotion Deodorant/ Antiperspirant Razors for Shaving During an observation of the facility on 8/29/11 at 2:30 p.m. A supply closet on the, "Cambridge" unit was unlocked, inside the closet were the following items, Hand Sanitizer (with a warning to keep away from children and suggested to seek professional assistance or consult poison control in case of accidental ingestion) Mouth Wash (with a warning to keep away from children) Denture Cleaner (with a warning to keep away from children) Shave Cream Toothpaste		appropriate (self locking) locks have been installed and are functioning properly.(B.) Elopement Risk binder has been reviewed by Social Services and have been updated as necessary.3. Systematic changes: (A.) Supply closets have been secured with automatic locking mechanisms and key access for staff only. Doors have been installed with automatic locks and require keys to open. ED/DNS will be responsible to make random checks of doors weekly of doors to ensure proper functioning. Maintenance will add supply closet doors to the monthly preventative maintenance rounds, as well to ensure compliance. (B.) Residents are assessed upon admission and quarterly thereafter for risk of wandering and elopement. Care Plan interventions are implemented as appropriate and those identified at risk are placed in the Elopement Risk binder at both nursing stations/front desk. Photo's are taken of those identified at risk and they are issues a CODE ALERT bracelet as a precautionary measure. 4. Monitoring: Unit Managers/designee/Social Services to monitor resident risk assessments for wandering and elopement upon admission, quarterly and/or with any change of condition. Residents are	

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	Body Soap and Lotion Deodorant/ Antiperspirant Razors for Shaving During an observation on 8/30/11 at 9:00 a.m. the "Brookshire" supply closet was still unlocked. During an interview with the maintenance person on 8/29/11 at 2:40 p.m., he indicated that all supply closets were to be locked and confirmed that they were not. During an interview with the maintenance person on 8/30/11 at 9:15 a.m., he indicated that he replaced the lock on the "Brookshire" supply closet and the closet was locked. Sixty-six residents out of the population of 119 resided on these two units B.1. The record for Resident #56 was reviewed on 8/31/11 at 2:30 p.m. Diagnoses included but were not limited to mild mental retardation, depression with psychotic features, and dementia with psychosis. A nurses note, dated for 8/13/11, indicated Resident #56 was "found outside of the building going down sidewalk in wheel		discussed in the morning clinical meeting with care plan interventions updated immediately. Social Services to review Elopment plans in PI committee monthly x3 or until compliance is achieved. Supply closet door security will be reviewed in monthly PI X3 months or until compliance is achieved. 5. Compliance Date: 10-6-2011.	

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	chair. Returned to building". The nurses note did not indicate how the resident got outside of the building. A facility "Wander/Elopement Risk Evaluation" form was completed on 8/26/10 indicating the resident was at risk for wandering, however not at risk for elopement. A facility care plan titled "Wandering" and dated 8/16/11 indicated the resident was found outside of building on 8/13/11 and required a "code alert" alarm (a bracelet type of device that warns staff resident is near an exit door). Further information was requested on 9/1/11 at 4:30 p.m., from the Executive Director (ED) and Director of Nursing Services (DNS), in regards to any interventions put in place from the date of 8/26/10 until the date of elopement on 8/13/11. No further information was available. 3.1-45(a)(1) 3.1-45(a)(2)			

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	155272	A. BUILDING 00 B. WING	09/06/2011

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F0325 SS=D	Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on interview and record review, the facility failed to identify and address changes in weight loss. This affected 1 of 5 residents reviewed for weight loss in a sample of 24 residents. Resident #23. Findings Include: The record for Resident #23 was reviewed on 8/31/11 at 9:45 a.m. Diagnoses included but were not limited to history of stroke, right femur (upper leg) fracture, chronic pain, vascular disease (restricted blood flow through vessels), right sided weakness, and dementia. The weight record for Resident #23 indicated a weight of 91.2 pounds on 6/6/11 and a weight of 85.1 on 7/20/11, indicating a 6.6% weight loss. A note from a Registered Dietician working with a local Hospice, written on	F0325	F 325It is the practice of the facility to ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that is not possible; and recieves a therapeutic diet when there is a nutritional problem. 1. Corrective Action: Resident #23 is a terminally ill resident with weight loss being documented as "expected" by the hospice Registered Dietician (RD) 7-20-2011. Resident #23 July weight was omitted from the Weight Entry system during a change in facility RD such that weight loss for July was not identified by contracting RD. This was an isolated error and not typical of RD services. Newly hired RD in place as of July 8, 20112. Identifying others: Weight records were reviewed by RD and Dietary Manager and no other residents were affected.3. Systematic Changes: Dietary Manager has been educated on the Resident Care System with regards to Weight Monitoring. RD has been inserviced by Regional	10/06/2011

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	7/20/11, indicated resident may be expected to lose weight as her disease process furthers, however there were no further dietary notes from the facility's Registered Dietician. A facility policy, dated 8/31/11, and titled "Nutritional Risk, Nutritional Problem and/or Significant Change", indicated staff will "identify nutrition interventions/goals and identify monitoring and evaluation criteria". Further information was requested on 8/31/11 at 4:30 p.m., from Executive Director and Director of Nursing Services, about the loss. No further information was available. 3.1-46(a)(1)		RD with respect to Weight Monitoring system and the identification of weight gain/losses. RD to review weight variations with Unit Managers/designee, DNS/ and interdiscipliary team in morning clinical meeting to identify those at risk for weight changes and implementation of interventions. 4. Monitoring System: RD will be responsible to monitor the weekly/monthly weights for completion and to evaluate and implement interventions as appropriate. Weight Changes are an on-going agenda item during our Monthly PI meeting. 5. Compliance Date: 10-6-2011.	
F0328 SS=D	The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.			

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	Based on record review and interview, the facility failed to ensure physician's orders were obtained and the plan of care was followed for a resident with a peripherally inserted central catheter (PICC) for 1 of 2 residents reviewed for PICC line care in a sample of 24. (Resident #145) Findings included: The record of Resident #145 was reviewed on 9/1/11 at 11:00 a.m. Diagnoses for Resident #145 included, but were not limited to, scrotal abscess status post surgery and paraplegia. Resident #145 was re-admitted to the facility on 6/14/11 with a PICC line. The PICC was discontinued on 7/7/11. A care plan for Resident #145, dated 3/10/11, indicated a problem of "Potential for complications associated with intravenous therapy...resident has ...PICC..." The goal was "Resident will remain free of signs and symptoms of infection associated with intravenous line through next review." Interventions included "1. Assess site every 8 hours. 2. Dressing changes to IV site as ordered...4. Note and report indications of infection at site such as redness, pain, swelling, drainage..."	F0328	F 328It is the practice of this facility to ensure that residents recieve proper treatment and care for special services.1. Corrective Action: Resident #145 had PICC line discontinued on 7-17-2011.2. Identifying Others: Residents with PICC lines had orders and care plans reviewed and updated as appropriate by Unit Manager/designee/DNS. 3. Systematic Changes: DNS educated licensed nursing staff on 9-15,16 and 18 and on 9-22, 23 and Oct. 2, 2011 with regards to PICC line care and documentation forms have been reviewed/educated.4. Monitoring: Unit Managers/designee will audit PICC line records daily x3 weeks and quarterly x2 for appropriate documentation and will provide follow up as necessary. ED/DNS/designee will monitor documentation weekly x 3 and monthly x2. Results will be reported to PI committee until compliance is achieved.Physician orders are being reviewed in the daily clinical meeting and PICC line orders reviewed and clarified as appropriate.5. Compliance Date: 10-6-2011.	10/06/2011

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Review of a "Midline and CVAD [central venous access device] Documentation Form" Form for July, 2011 indicated:

"IV Assessment [every] 8 hours and PRN [as needed]: Initials indicate: No visible or palpable signs of complications at insertion site or along vein pathway, catheter properly secured, dsg [dressing] adherent and intact with no moisture under dsg, all lumens have injection caps in place, caps are secure, lumens not in use are clamped." There were 3 boxes, one for each 8 hour shift every day for the nurse to initial the results of her assessment. On 7/1/11 and 7/2/11, there were no initials in any of the 6 boxes. On 7/3/11, there were no initials in the night or day shift boxes. On 7/4/11 and 7/5/11, there were no initials in the day shift boxes. On 7/6/11, there were no initials in the day or evening shift boxes.

A review of physician's orders for Resident #145 did not indicate the facility had obtained physician's orders for care of the PICC line.

Further information was requested from the Director of Nursing on 9/2/11 at 5:00 p.m., regarding physician orders and assessments of Resident #145's PICC line.

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	No further information regarding physician's orders and assessments of Resident #145's PICC line was provided by final exit on 9/6/11 at 4:45 p.m. 3.1-47(a)(2)			
F0329 SS=E	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure gradual dose reductions were considered, residents' pain was assessed prior to and after administering pain medications and heart rates were taken prior to administering a blood pressure medication for 9 of 21	F0329	F 0329It is the practice of this facility to to ensure gradual dose reductions are considered, residents' pain assessed prior to and after the administration of pain medications and heart rates taken prior to administering a blood pressure medication. 1. Corrective Action: Medications	10/06/2011

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	residents reviewed for receiving excessive and/or necessary doses of medication in a sample of 24. (Residents #49, #145, #152, #13, #38, #153, #98, #23 and #56) Findings included: 1. The record of Resident #49 was reviewed on 8/29/11 at 1:45 p.m. Diagnoses for Resident #A included, but were not limited to, high blood pressure, tachycardia (fast heart rate) and heart failure. A physician's order for July 8, 2011, indicated Resident #49 was to receive Metoprolol (a blood pressure medication) 75 milligrams every 8 hours and the medication was to be held if the resident's heart rate was less than 70. A cardiac care plan for Resident #49, dated 5/19/11, indicated she had a potential for "alteration in cardiac output." The goal was "Resident's heart rate will be within normal range of 60 to 90 bpm [beats per minute] while at rest." Interventions included "Monitor heart rate daily or as ordered...administer cardiac medications as ordered..." Review of a Medication Record for Resident #49 for July, 2011, indicated of		for Residents #49(Actually, Resident #144), 145, 152, 12, 38, 153, 98, 23 and 56 were reviewed with Nurse Practioner/MD for appropriateness and/or potential for reduction.2. Identifying Others: Those residents with HR (Vital Signs) required prior to the administration of medications have been identified through our Resident Care System and orders reviewed for appropriateness. Residents with pain medication ordered were also identified using the Resident Care System and were reviewed for appropriateness and potential for reduction with Nurse Practioner/MD.3. Systematic Changes: DNS inserviced licensed staff on 9-15, 16 and 18 and on 9-22, 23 and Oct. 2, 2011 with regards to obtaining necessary vital signs governing the administration of medications within parameter requirements, gradual dose reductions, the pre/post pain assessments. Unit Managers/designee will be checking MARs (Medication Administration Records) daily to ensure compliance and will follow up with staff as appropriate. New orders are reviewed in the daily clinical meeting for appropriate follow through and clarification if necessary. Monthly meeting by IDT to evaluate GDR will be held to review appropriateness of reductions/effectiveness. 4. Monitoring: New orders will be monitored in the daily clinical	

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	the 69 scheduled times when Metoprolol was to be given (July 9, 2011 through July 31, 2011) Resident #49's heart rate was checked only 1 time, 7/11/11 at 6:00 a.m. During an interview with the Director of Nursing on 9/2/11 at 10:00 a.m., she indicated she was not able to find any other times when Resident #49's heart rate was checked prior to the administration of Metoprolol during July, 2011. 2. The record of Resident #145 was reviewed on 9/1/11 at 11:00 a.m. Diagnoses for Resident #145 included, but were not limited to, acute pain, scrotal abscess and paraplegia. A care plan for Resident #145, dated 6/3/11, indicated a problem of actual pain related to wounds. The goal was "Resident will verbalize relief or lessening of pain within one hour of receiving interventions." Interventions included "...5. Evaluate effectiveness of interventions with in one hour..." A recapitulated physician's order for August, 2011, with an original date of 6/21/11 indicated Resident #145 received 90 milligrams of Morphine every 8 hours scheduled for pain.		meeting for appropriateness and follow through. MAR will be checked daily by the Unit Manager/designee with follow up as appropriate. DNS/ED will monitor MAR weekly x3, monthly x2in PI committee or until compliance is achieved. IDT chaired by SS will report on GDR committee findings monthly X3 or until compliance has been achieved.5. Compliance Date: 10-6-2011	

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	Another recapitulated physician's order for August, 2011, with an original date of 6/14/11, indicated Resident #145 could also receive Hydrocodone 3/325 milligrams (a narcotic pain medication) 1 or 2 tablets every 4 hours as needed for severe pain. Review of a Controlled Drug Record for Resident #145 for July, 2011, indicated he received 2 tablets of Hydrocodone as needed 114 times during the month. Review of the July, 2011 Medication Record and Pain Monitoring Flowsheet for Resident #145 indicated only 14 times when his pain was assessed prior to and after receiving the Hydrocodone. (July 3, at 10:00 p.m., July 4, at 3:00 a.m. July 13 at 6:00 p.m., July 16 at 11:20 a.m., July 17 at 1:00 a.m., July 18 at 5:00 p.m. and 9:00 p.m., July 19 at 6:00 p.m. and 10:00 p.m., July 24 at 2:00 a.m. and 6:00 a.m., July 29 at 6:00 p.m. and 11:00 p.m. and July 30 at 6:00 a.m.) Further information was requested from the Director of Nursing on 9/2/11 at 5:00 p.m., regarding any pre and post pain assessments being done for the remaining 100 administrations of Hydrocodone to Resident #145 during July, 2011. No further information was provided			

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	regarding the lack of pre and post pain assessments for 100 administrations of Hydrocodone to Resident #/145 by the final exit on 9/6/11 at 4:45 p.m. 3. The clinical record for Resident #152 was reviewed on 9/1/11 at 2:50 p.m. The diagnoses for Resident #152 included, but were not limited to: Depression, Hyperlipidemia, Morbid Obesity, Heart Disease, Renal Dialysis Status, and Left Foot Transmetatarsal Amputation. The September, 2011 physician's recapitulation orders for Resident #152 indicated two 5mg capsules of Oxycodone Hydrochloride to be given by mouth every 4 hours as needed on pain scale of 1-10 beginning 8/2/11 and one 2 mg tablet of Hydromorphone, substitute for Delaudid, to be given by mouth every 6 hours as needed on pain scale of 1-10 beginning 8/2/11. The August, 2011 MAR (Medication Administration Record) for Resident #152 indicated Oxycodone was given on 8/6/11 and Delaudid was given on 8/5/11 and 8/16/11. There was no documentation to indicate the resident was assessed for the location or intensity/nature of the pain prior to administering the pain medication or for the effectiveness of the medication			

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	after the medication was given. The pain care plan for Resident #152 indicated interventions were to provide medications as ordered and to notify MD (medical doctor) if pains persist or interventions continue to be ineffective. Further information was requested on 9/1/11 at 4:00 p.m., from the Executive Director and Director of Nursing Services and no further information was available. 4. The clinical record for Resident #38 was reviewed on 9/1/11 at 10:10 a.m. The diagnoses for Resident #38 included, but were not limited to: Hypertension, Arthritis, Puritis, Mental Disorder, Senile Dementia, Pemphigoid, Neuropathy, and Constipation. The September, 2011 physician's recapitulation orders for Resident #152 indicated one 5/325 mg tablet of Hydrocodone, substitute for Norco ,to be given by mouth every 4 hours as needed for pain on pain scale of 1-10 beginning 3/31/11. The August, 2011 MAR for Resident #38 indicated Norco was given on 8/13/11 and 8/19/11. There was no documentation to indicate the resident was assessed for the			

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	location or intensity/nature of the pain prior to administering the pain medication or for the effectiveness of the medication after the medication was given. The pain care plan for Resident #38 indicated interventions were to administer pain medication as ordered and to evaluate effectiveness of interventions within one hour. Further information was requested on 9/1/11 at 4:00 p.m., from the Executive Director and Director of Nursing Services and no further information was available. 5. The clinical record for Resident #13 was reviewed on 8/30/11 at 9:15 a.m. The diagnoses for Resident #13 included, but were not limited to: Depression, Anxiety, and Panic Attacks. The physician's recapitulation orders for Resident #13 indicated one 50 mg tablet of Sertraline HCL, substitute for Zoloft, to be given by mouth daily beginning 8/24/10. No information could be found in the clinical record to indicate a GDR (Gradual Dose Reduction) was considered since 8/24/10. During interview with the Social Services Director on 8/30/11 at 2:50 p.m., she			

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	indicated a GDR did not have to be considered because there was a standing order, dated 8/24/10, indicating a GDR is contraindicated due to resident continues to be tearful at times. The psychotropic medication care plan for Resident #13 indicated an intervention was to consult physician for medication evaluations/reviews as needed. 6. The record of Resident #153 was reviewed on 8/29/11 at 10:00 A.M. Diagnoses for Resident #153 included but were not limited to end stage renal disease and open leg wounds of non healing ulcers During a review of the medication record of Resident #153 on 8/30/11 at 10:15 A.M., pre and post evaluations of 30 mg of Oxycodone, given as needed for pain control, could not be found for the administration of 23 of 24 doses of this medicine given in July and 19 of 26 doses given in August. At 10:35 A.M., on 8/30/11, during an interview with the DON, she provided a copy of documentation for pre and post evaluations of the administration of 30mg of Oxycodone, completed once on 7/29/11 of the 24 doses given for the month of July and completed 7 times in the month			

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of August on 8/1 (x1), 8/3 (x2), 8/6 (x1), 8/28 (x2) and 8/30 (x1) out of 26 doses given. She indicated that there were no other administration evaluations of this pain medicine that could be found.

7. The clinical record for Resident #98 was reviewed on 8/30/11 at 9:30 a.m.

Diagnoses for Resident #98 included but was not limited to, tracheostomy (a hole in the trachea for breathing), COPD (Chronic Obstructive Pulmonary Disease), oropharyngeal cancer (cancer of the throat), and gastric tube (a tube placed into the stomach for liquid nutrition and medication for people who are not able to swallow or eat).

A physicians order, dated 8/12/11, indicated resident was to receive Morphine Sulfate, 30 milligrams (mg), every 3 hours around the clock.

A facility care plan for "Alteration in Comfort" indicated resident should be observed every 2 hours for signs and symptoms of pain.

A facility "Pain Monitoring Flowsheet" indicated Resident #98 was not assessed for pain on 8/18, 8/19 , 8/20, 8/25, 8/26, 8/27, or 8/28/2011.

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KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON	5226 E 82ND ST INDIANAPOLIS, IN46250

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	During an interview with the Director of Nursing Services (DNS) on 8/31/11 at 5:35 p.m., she indicated that it would be her expectation that pain is assessed daily. Further information was requested on 9/1/11 at 4:00 p.m., from the Executive Director and Director of Nursing Services and no further information was available. 8. The clinical record for Resident #23 was reviewed on 8/31/11 at 9:45 a.m. Diagnoses included but were not limited to history of stroke, right femur (upper leg) fracture, chronic pain, vascular disease (restricted blood flow through vessels), right sided weakness, and dementia. A recapitulated physicians order for September, 2011 indicated the resident was taking the following medications, Namenda 10 milligrams (mg), 1 tablet by mouth two times daily for dementia Trazadone 50 mg give 1 tablet by mouth every evening at bed time Ativan 0.5 mg, give 1 tablet by mouth every 12 hours for anxiety and every 4 hours as needed for anxiety Lexapro 20mg, give 1 tablet by mouth daily Aricept 10 mg, give 1 tablet by mouth at			

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	hour of sleep A "Psychiatric Follow Up," dated 8/24/2010, indicated this was the last time these medications were reviewed by a physician. There was no other information found in the clinical record in regards to recent reviewing or monitoring of Resident #23's antipsychotic medications to suggest that all the medications were still necessary for treatment. 9. The record for Resident #56 was reviewed on 8/31/11 at 2:30 p.m. Diagnoses included but were not limited to mild mental retardation, depression with psychotic features, and dementia with psychosis. A recapitulated physicians order for September, 2011 indicated the resident was taking the following medications, Zyprexa 10 mg, give 1 tablet by mouth every day at 1700 (5:00 p.m.). Zoloft 100 mg, give 1 tablet by mouth every day at 1700 On 4/16/10, a pharmacy "Note to Attending Physician/Prescriber" indicated Resident #56's Zoloft and Zyprexa were due for dose reduction evaluations or justification for continuing current doses.			

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	The physician kept Resident #56 at current dose at that time of review, because the treatment was keeping the resident's mood stable. Further information was requested from DNS and ED on 8/31/11 at 5:00 p.m., for both Resident #56 and Resident #23 in regards to any recent gradual dose reductions, reviews or further monitoring of the antipsychotic medications. No further information was provided for review. 3.1-48(a)(3) 3.1-48(a)(6) 3.1-48(b)(1) 3.1-48(b)(2)			
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and record review, the facility failed to ensure safe food	F0371	F 0371It is the practice of this facility to store/prepare/serve under santitary condions.1.	10/06/2011

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	handling by not maintaining food temperatures at the safe serving level, covering facial hair, labeling food with the date in which it was opened, and thawing meat above other foods. This had the potential to effect 115 of 119 residents who receive their meals from the facility kitchen. Findings include: During the initial tour of the facility kitchen on 8/29/11 at 11:15 a.m., the following foods were found to be open, with no open dates, 1 box of rice 1 box of muffin mix 1 box of chocolate chips 1 bag of egg noodles 1 bag of macaroni noodles 5 containers of cereal, 2 containers were loose enough that air and contaminants could get through 1 bag of cereal 1 box of thickener 1 gallon of milk 2 open blocks of butter During initial tour the following food items were found to be expired, 1 bag of hamburger buns, marked "good thru" 8/23/11. 2 boxes of cucumbers, no expiration date printed, with visible mold on the		Corrective Action: Dietary Manager (DM) educated on elements of tag F371 and Performance Improvement Plan intiated. Dietary department will be deep cleaned thoroughly by 10-6-2011. 2. Identifying Others: DM/RD (Registered Dietician) and ED (Executive Director) are performing Nutritional Quick Rounds and sanitation checks of the kitchen and surrounding area on a daily basis (DM) with RD, ED/Designee performing the Quick Rounds weekly. DM is expected to correct any negative finding identified on the Quick Round immediately or within 24 hours.3. Systematic Changes: DM and RD, under the direction of the Regional Dietary Services Manager have inserviced the dietary staff on 9-21-2011 regarding dietary standards, i.e. (dating of open containers, expiration of food items, thawing of meat, covering of facial hair, food temperatures. DM has Performance Improvement Plans in place for the following areas:Facial Hair Covering/Hair nets, Taking/Recording proper food temperatures, Thawing/Storing of Raw Meats, Labeling of Opened Food Items, and Sanitation. Each dietary employee was required to attend the education and to sign off the materials presented. Specific job assignements were reviewed with	

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	cucumbers. During initial tour the following observations were made: Frozen meat, hamburger and pork loin were on silver baking sheet-type pans thawing in the refrigerator above boxes of juice. Three male employees with facial hair were not wearing any beard covers. Employee #'s 1, 2 and 3. During the lunch meal on 8/29/11 at 12:30 p.m., the Dietary Manager (DM), took temperatures of the food being served from the steam table. Temperatures that were not considered to be in safe range were, Pureed Meat 114 degrees Fahrenheit (F) Baked Chicken 130 degrees F Egg Noodles 114 degrees F During the evening meal on 8/31/11 at 5:00 p.m., the DM took temperatures of the food being served from the steam table and rack where cool foods were kept. Temperatures that were not considered to be in safe range were, Chicken Pot Pie 135 degrees F Cooked Cabbage 135 degrees F Noodles 125 degrees F Pureed Chicken 121 degrees F Soup 123 degrees F Strawberry Yogurt 64 degrees F		dietary staff and clear expectations outlined. 4. Monitoring: Dietary Manager is responsible to ensure the overall compliance of the Dietary Department. Specific shift responsibilities for monitoring of food temperatures, food storage, thawing/storing of raw meat, hair nets/hair coverings have been assigned. DM is responsible to ensure that assignements are monitored daily Monday- Friday, with the cook responsible for monitoring for compliance on the weekend. RD is also responsible to monitor logs weekly x3 and then quarterly x2. ED/designee will conduct random audits weekly x3 and quarterly x2. DM/RD to bring findings to PI committee monthly x3 or until compliance achieved. ED ultimately responsible to ensure that DM achieving overall compliance in the Dietary department. 5. Compliance Date: 10-6-2011	

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	Cottage Cheese 67 degrees F A facility policy dated 4/28/10, titled "Nutrition Services Evaluation: Sanitation/Food Safety Checklist" included: "...facial hair is not allowed or covered by beard restraint." "Prevent juices from raw meats, poultry and fish from contacting other foods.", and "Foods are held such that internal temp (temperature) is 41 degrees of below or 140 degrees or above." This federal tag relates to Complaint IN00094314 3.1-21(i)(3)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on clinical record review and interview, the facility failed to ensure the nursing staff maintained professional	F0514	F 0514It is the practice of this facility to ensure that nrusing staff maintains professional standards in regards to the documentation	10/06/2011

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	standards in regard to the documentation of medication administration or catheter care for 2 of 24 resident records reviewed for complete and accurate documentation out of a sample of 24 residents Residents # 153 & #118 Findings include: 1. The record of Resident #153 was reviewed on 8/29/11 at 10:00 A.M. Diagnoses for Resident #153 included but were not limited to end stage renal disease and open leg wounds of non healing ulcers. On 8/29/11 at 10:30 A.M., the medication records of July and August, 2011 of Resident #153 were reviewed and indicated that the medicines were not given according to physician orders. Medications not given were designated by nurses initials in a circle or space not marked. A designated space was provided on the back of record for explanations for the circling or omissions to be put on appropriate line by the date. No notations on records for non administration of the following medicines could be found: Heparin, 5000 units, dispensed by syringe every 8 hours - missed doses were found		of medication administration or catheter care for complete and accurate documentation. 1. Corrective Action: Resident #153 has been discharged home. Resident # 118 resides in the facility and has had no negative outcome.2. Identifying others: MAR/TAR records have been audited by unit managers/designee and orders/instructions clarified where appropriate. Those with catheters have been identified using the Resident Care System and orders for catheter care have been reviewed and clarified.3. Systematic Changes: DNS educated licensed staff on 9-15, 16 and 18 and 9-22, 23 and Oct. 2, 2011 with regards to medical record documentation requirements, following policy and accurate recording of documentation.4. Monitoring: Unit Managers/designee to monitor clinical records daily x 3 weeks and then quarterly x2 for completion. DNS/ED/designee to monitor weekly x 3 and then monthly x2 with results forwarded to PI committee until compliance achieved.5. Completion Date: 10-6-2011.	

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	on 7/3, 2:00 P.M. (circle) - 7/4, 2:00 P.M. (circle) - 7/8, 10:00 P.M. (circle) - 7/9, 6:00 A.M. (circle) - 7/10, 2:00 P.M. (circle) and 7/11, 6:00 A.M. (circle). Sodium Thiosulfate, 25gm on dialysis days after intravenous administration on Tuesday, Thursday and Saturday - missed doses were found on 7/12 (space) - 7/14 (space) and 7/21 (space). Renagel, 800 mg, 4 tabs 3 times a day with meals - missed doses were found on 7/13 at 8:00 A.M. (circle) and 12:00 P.M., (circle) - 7/15 at 8:00 A.M. (space) and 12:00 P.M., (space) - 7/19 at 12:00 P.M., (circle) - 7/20 at 5:00 P.M. (space) - 8/5 at 8:00 A.M. (space) and 12:00 P.M. (space) - 8/11 at 8:00 A.M. (circle) - 8/12 at 8:00 A.M. (circle) and 12:00 P.M. (circle) - and 8/19 at 12:00 P.M. (space). Fluoxetine HCL, 10 mg. capsule, 1 capsule by mouth every day - missed doses were found on 8/5, (space) - 8/11, (circle) - 8/12 (circle) - and 8/19 ((space). Cinacalet, 60 mg tab, 1 tab by mouth daily with food - missed doses were found on 8/5 - (space) - 8/10 (circle) and 8/11 (circle).			

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	Pregabalin, 50 mg capsule, 1 capsule by mouth every day at bedtime - missed doses were found on 8/19 (space) and 8/31 (circle). Prostat 64, 30 ml by mouth 3 times daily - missed doses were found on 8/9 at 8:00 A.M. (space) and 12:00 P.M. (space) - 8/11 at 12:00 P.M. (space) 8/12 at 12:00 P.M. (space) - 8/15 at 12:00 P.M. (space) - 8/19 at 8:00 A.M. (space) and 12:00 P.M. (space) and 8/26 at 12:00 P.M. (space). Oxycodone SA, 40 mg by mouth 2 times a day - missed doses were found on 7/3 at 9:00 A.M. (space) 8/5 at 9:00 A.M. (space) - 8/15 at 9:00 A.M. (space) and 12:00 P.M. (space) - and 8/16 at 9:00 A.M. (space). An interview was conducted with LPN #6 at 2:15 P.M., concerning charting of medications for Resident #153. She said that circles around initials on the medication administration record meant the medication was not given by the nurse whose initials are in the circle, and an explanation was to be placed on the back of the sheet. She indicated if there was a circle with initials, the medication was not given for some reason at that time, and if there was a blank space on the record the medication may not have been given or			

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	the person may have been gone. She said she was not sure why there were circles or blank spaces During an interview on 9/1/11 at 5:00 P.M., with the Director of Nursing (DON) and Executive Administrator of the facility, they were informed that documentation of medicines not given for Resident # 153 was missing in the medication record. On 9/2/11 at 9:30 A.M., the DON indicated that no other medication documentation could be found for Resident #153. 2. Resident #118's clinical record was reviewed on 8/30/2011 at 10:30 a.m. The record contained documentation of Resident #118 having been admitted to the facility on 6/30/2008. The record contained diagnoses that included, but were not limited to, Paraplegia, Major Depressive Disorder, Seizure Disorder, and Neurogenic Bladder. An order listed on the treatment record sheet, dated 4/14/2011, indicated that Suprapubic catheter care with warm soapy water was to be documented every shift and as needed. On the 7 a.m. to 3 p.m. shift, no initials or notes related to care completion were found for the following dates; 7/3/2011,7/4/2011, 7/5/2011, 7/6/2011,			

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	7/7/2011, 7/8/201, 7/10/2011, 7/11/2011, 7/13/2011, 7/14/2011, 7/15/2011, 7/22/2011, 7/23/2011. On the 3 p.m. to 11 p.m. shift, no initials or notes related to care completion were found on the following dates; 7/15/2011, 7/23/2011, 7/24/2011, 7/28/2011. On the 11 p.m. to 7 a.m. shift, no initials or notes related to care completion were found on the following dates; 7/24/2011 and 7/27/2011. An interview with wound care nurse, LPN #7, on 9/02/2011 at 10:35 a.m,. indicated Resident #118 was provided catheter care each shift and more frequently if needed to prevent skin breakdown. An interview with LPN #8 on 9/02/2011 at 11:52 a.m., indicated that Resident #118 receives catheter care once a shift plus as needed. 3.1-50(a)(1)			